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ABSTRACT

A sociopsychological approach is applied to social systems in examining the community mental health center movement. The interrelated concepts of task(s), social structure, culture, and social process help explicate the overwhelming emphasis on direct clinical service at the cost of indirect service. The historical evolution of the task-mandate and the professional and organizational structures of the CMHCs to their legislative origins is traced. Nonrational aspects of the social process during the 1960's contributed to an illusion of radical social change, despite the actual ongoing predominance of the clinical approach. Considering possible future directions of the community mental health center, the authors describe the advantages of a sociopsychological approach in providing a conceptual base for the integration of direct and indirect services. (Author)

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The Community Mental Health Center Movement:

A Social System Analysis

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The community mental health center movement was set in motion by the Mental Health Study Act of 1955. Eight years later, in 1963, the movement's supporters at the National Institute of Mental Health won the struggle for federal legislation to build and fund community mental health centers. Since that time, excensive amounts of effort and money have gone to creating the new centers and to expanding existing mental health services. As federal funds are being withdrawn, increased attention is now being given to evaluating their results. The movement itself had an active life of at most ten years, from the mid-1960's to the present time, and is now in a period of transition either to death or renewal.

A major problem in evaluating community mental health centers is the lack of consensus regarding the definition of major tasks and their respective priorities. The absence of a working theory of social structure and social process among mental health professionals has been a major source of the ambiguity and misunderstanding regarding task(s). It has contributed to the illusion that we were engaged in a large scale effort at social change through community mental health during the 1960's. Further, there is now wide-spread gloom over what is misperceived as a clinical retrenchment within the mental health field. When we examine what has been accomplished by the community mental health center from the perspective of its original task-mandate, we find that the "retrenchment" of the 1970's primarily involves the shrinking domain of fantasy.

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A primary rationale for this analysis is that the community mental health center movement ought not to be faulted for failing to do something it was never intended to do. Such a view would serve conservative reaction in four ways; (1) by justifying funding cuts from mental health programs; (2) by providing further "proof" that HEW government funded social programs never work; (3) by allowing people to imagine that a radical community mental health program existed and that it failed; and (4) by diverting attention from the advances that have been made and discouraging efforts to extend them.

In this presentation, we will focus on the application of certain theoretical concepts, i.e. task, social structure and social process, in examining the community mental health center program. Employing these concepts helps explain why there has been an overwhelming emphasis on direct clinical services at the cost of indirect or preventive services.

The Concept of Task

Task refers to issues of definition--we restrict its use to mean the end toward which work is aimed; of priority--we distinguish between major and primary tasks since organizations typically have two or three major tasks of which one is primary; and of compatibility--the extent to which tasks are noncompeting and efforts at task completion can be integrated within an organization.

The two central tasks of the community mental health center involve the development of a wide range of direct patient services and of indirect mental health services (i.e., consultation and mental health education). Most agree that the 1963 federal legislation sought to bring about the broader and more equitable provision of direct mental health services to the general public. In contrast, there is considerable confusion and dissensus about the definition and priority of the second task, the development of indirect services. Many thought that the latter task was intended to be far more central than is

currently the case. The 1972-73 annual NIMH inventory indicates that less than 5% of staff time goes into indirect services in community mental health centers despite the fact that prevention received special emphasis in Kennedy's 1963 presidential message.

The proposals and changes in relation to direct mental health services represented a kind of progressive, liberal reform. These were viewed as necessary to correct inequities and limitations in the system of service delivery, and were relatively easy to accept. In contrast, the indirect service task implied the most radical change. Consequently, the controversy within the community mental health center movement primarily revolved around the provision of indirect services. By their nature, these services required the greatest degree of change from a medical identity, in organizational structure, and in ideology. They necessitated the development of public health, consultation and community intervention skills and approaches which traditionally have been resisted by clinical psychology, psychiatry and the other mental health disciplines. The indirect service task was consistently viewed with great ambivalence, and never was given clear definition or substantial support.

A focus on task in relation to pertinent mental health legislation and reports makes evident the true mandate of the community mental health center program.

Mental Health Study Act of 1955

A close reading of the task-mandate in this Act indicates that the priority was on diagnosis, treatment and rehabilitation of the mentally ill, and the stated research support was made in relation to these clinical activities. The resolution concerned itself with the economics of providing care to the mentally ill, and on questions of resources and manpower.

Report of Joint Commission on Mental Illness and Health

The recommendations made by the Commission at the completion of its study (Action for Mental Health, 1961) focused on the need to expand clinical facilities and services. The report did not include recommendations to develop public health or primary preventive programs, and did not speak to the development and integration of direct and indirect services.

1963 Federal Community Mental Health Centers Act

The federal legislation and the operational guidelines established by NIMH provide the best indication of the task priorities of the community mental health center program. The program was outlined as incorporating both prevention and treatment approaches, direct and indirect mental health services. However, the indirect service task was given a very secondary position. Five essential services were defined. The first four defined the clinical direct service task and only the fifth was given to the definition of the indirect service task. On close examination, even indirect services turned out to feature clinical service, as they were defined largely in terms of an extension of the direct service delivery system through primary caregivers in the community. Preventive efforts were very secondary.

The Concept of Social Structure

Social structure, in this analysis, refers to issues of organizational settings and professional divisions of authority and labor. Employing this concept also helps to illuminate aspects of the nature and outcome of the community mental health center movement. For example, the work of the Joint Commission greatly influenced the federal legislation that formed the basis for the community mental health center program. An examination of the professional structure of the Commission helps to understand the nature and direction of this program. The leadership of the Commission involved promin-

ent members from the American Psychiatric Association and the American Medical Association. Twenty-five members of the forty-five member Commission had M.D.s, 7 Ph.D.s, 4 other degrees and 9 had no degrees listed. A review of the 36 participating associations reveals the medical and allied-medical character of the Commission. Even before the initiation of the study itself, the choice to involve these particular groups and not others (e.g., groups representing the poor and minorities) and the resulting membership of the Commission, created a strong bias in the direction of an individualistic point of view, a clinical treatment frame of reference, and ultimately a recommendation that psychiatry enlarge itself. An individualistic-clinical, ideological bias would inevitably permeate the final report and the solutions that it proposed.

Following the enactment of the 1963 federal legislation, decisions regarding social structural features of the community mental health center program would greatly influence its outcome. Many of the centers were established within, or in conjunction with, existing general hospitals or university medical schools which means that they reside within a larger organization that primarily supports treatment and remedial programs and embraces an individual, disease-model orientation and clinical frame of reference. Furthermore, the staffing patterns for these programs consist essentially of positions for mental health professionals from the existing clinical disciplines. These professionals would tend strongly to continue providing clinical services even though carried out in community-based settings. It is clear that matters related to organizational structure and resource allocation overwhelmingly favor clinical service.

The Concept of Social Process

Here we focus upon those collective fantasies that provide a symbol-

ization of behavior and activity that elaborates and may vastly enlarge or otherwise distort it. In order to understand the development of the illusion of a large scale effort in social change through community mental health, one must examine the influence of the social process of the 1960's on the mental health field. One source of the confusion can be attributed to NIMH's victory for control of the community mental health center program in the intra-federal health bureaucracy political struggles. By 1961, there were three separate national mental health plans submitted by three competing, if partially overlapping, groups. These may be arrayed from right to left as follows: the Surgeon-General's Committee joining state health (and hospital) authorities with federal representatives of the Public Health Service; the Joint Commission on Mental Illness and Health; and a planning group of NIMH staff. From NIMH's point of view, the reports from both of the other groups were too conservative in their willingness to countenance a continuation at some level of the state hospital system. For a growing young activist institute, the state hospital system was not only bad for patients, it also left too much power in the hands of the state superintendents and the federal Public Health Service. Ultimately, NIMH's recommendations to President Kennedy proved decisive.

If NIMH was to the left of the Joint Commission and the Public Health Service, then it could be imagined that they were on the left in some more absolute sense. In fact, their view of public health was every bit as disease-oriented as was the private practitioner's or the hospital psychiatrist's. They envisioned relaible, mass screening and diagnosis, early detection, and briefer outpatient clinic treatment available in every community. If this was progressive compared with the state hospital system, it was hardly a revolutionary assault upon the social order. But by the time this essentially

meliorist program was implemented, revolution--or rather, revolutionary imagery--had formed the collective anlage of the day.

The community mental health program was conceived of and developed in the 1950's and early 1960's when the social mood was more conservative. The 1960's, by contrast, was more a period of political activism and social reform. The mental health professions became a part of this social process. Greater attention was being paid to social factors and their role in facilitating or limiting individual functioning.

Mental health professionals were caught up in the moral conflicts generated by the social critique and attempts at reform. That is not to say that everyone joined in, conceiving of the effort as part of their responsibility as mental health professionals. It is to say that even to stay out of it involved continued effortful, troubled preoccupation and dilemma. In actual fact, only a small percentage of mental health professionals ever left their offices and wards or became involved in any service activity that was genuinely extra-clinical. Nonetheless, the conviction arose, held in horror by some and with triumph by others, that basic changes were underway in mental health and in society.

Thus by the mid-1960's (and especially after the intensification of the war in Vietnam and the opposition to it), the activities of community mental health professionals were becoming defined in their own minds and others as radical--part of the larger attack on a pernicious, sick society. Nonetheless, the majority of time and effort continued to be spent in carrying out the primary task of the program, that of developing and implementing extended clinical services on a community basis. Yet by partaking of the collective imagery of the 1960's, an illusion developed for many individuals in the mental health profession that a basic shift in ideology was occurring in the men-

tal health field toward a social frame of reference. People thought--again, some with alarm, others with satisfaction--that the indirect service task was becoming equal to the clinical task and that efforts in these areas would increase on into the future.

Although the social reform climate of the 1960's had encouraged the initiation of preventive efforts through certain limited components of the community mental health center, there was no enduring organization-wide structural change to support and sustain these efforts. They remained captive to the medical organizations and the clinical professions. As the social process shifted with Nixon and the reaction of the early 1970's, the underlying social structural foundations of the community mental health center reemerged. Despite the reform influences from the 1960's, the policy decisions, task priorities and definitions, and other structural arrangements made during the planning phases in the Eisenhower years remained intact.

Changes in the social process occur over time and have varying influences on programs and institutions. However, since social structural factors are most enduring, without change in the structural bases of a program, the social process influences will dissipate in time as the mood and climate of the culture change. In the case of the community mental health center program, the overwhelming commitment to the clinical task becomes clear, while the indirect service task seems to wither away, as though it were an unsuccessful effort, when in fact it had never received substantial support.